# COGME Meeting
# April 10 - 11, 2003, Bethesda, Maryland

# Agenda

**THURSDAY, APRIL 10**

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8:30 a.m. Welcome from Chair & Minutes

Carl J. Getto, M.D., Chair

Welcome from Health Resources and Services Administration
Elizabeth M. Duke
Administrator

Welcome from the Bureau of Health Professions
Kerry Nesseler, RN, M.S.
Associate Administrator for Health Professions

Welcome and Acting Executive Secretary=s Report
Stanford M. Bastacky, D.M.D., M.H.S.A.
Acting Executive Secretary, COGME

9:00 a.m. Impact of Malpractice Insurance on Physician Practice

Emily V. Cornell, M.S.W., Program Director
Maternal and Child Health Policy Studies Division
National Governors Association

Ross Rubin
Vice President for Legislative Affairs
American Medical Association

Chip Slaven,
Special Assistant to the Governor
of West Virginia

10:00 a.m. Discussion

10:30 a.m. Break

10:45 a.m. Impact of Residency Duty Hours Restriction–Cost and Structural Adaptations

Marvin R. Dunn, M.D.
Director of Residency Review Committee Activities
Accreditation Council for Graduate Medical Education

Mark Levy
Executive Director, Council of Interns and Residents

Danielle Carrier
Program Director for Operations Improvement
University Health System Consortium

11:45 a.m. Discussion

12:15 p.m. Lunch

1:30 p.m. Assessment of Medicare's IME Payments for GME

Craig Lisk
Staff member, MedPAC

Robert M. Dickler
Senior Vice President, Association of American Medical Colleges

2:15 p.m. Public Comment

2:30 p.m. Breakout of Workgroups

Diversity Workgroup
GME Financing Workgroup
Workforce Workgroup

4:30 p.m. ADJOURN

**FRIDAY, April 11**

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8:30 a.m. Discussion of the Report of the Institute of Medicine, "Health Professions Education: A Bridge to Quality"

9:00 a.m. Reports by Workgroup Chairs

9:45 a.m. Development of a Framework for Revised COGME Physician Workforce Goals

Ed Salsberg
Director, Center for Health Workforce Studies
State University of New York at Albany

10:45 a.m. Break

11:00 a.m. Discussion of Future Work

11:45 a.m. Public Comment

12:00 p.m. ADJOURN

# Minutes

The Council on Graduate Medical Education (COGME) convened at 8:44 a.m. on April 10 in the Versailles IV Meeting Room of the Holiday Inn Select, Bethesda, MD. Dr. Carl J. Getto, COGME Chair presided. The plenary meeting concluded that day at 2:33 p.m. It reconvened the next morning, April 11 at 8:30 a.m. in the same room and adjourned at 11:22 p.m. that day.

**Members Present:**

Carl J. Getto, M.D., Chair
Laurinda Calongne, LCSW-BACS, Member
William Ching, Member
Allen Irwin Hyman, M.D., FCCM, Member
Robert L. Johnson, M.D., Member
Lucy Montalvo, M.D., M.P.H., Member
Jerry Alan Royer, M.D., M.B.A., Member
Susan Schooley, M.D., Member
Humphrey Taylor, Member
Douglas L. Wood, D.O., Ph.D., Member
Tzvi M. Hefter, Designee of the Centers for Medicare and Medicaid Services
Stephanie H. Pincus, M.D., M.B.A., Designee of the Department of Veterans Affairs
Howard Zucker, M.D., Designee of the Acting Assistant Secretary for Health

**Members absent:**

Regina M. Benjamin, M.D., M.B.A., Member
Donald C. Thomas III, M.D., Member

**Staff:**

Jerald Katzoff, Acting Deputy Executive Secretary
Howard Davis, Ph.D.
Helen Lotsikas, M.A.
Eva Stone

**Welcome and Announcements:**

**Dr. Getto** welcomed participants to the meeting. He took note of Dr. Marian Bishop□s passing on March 15, 2003 and gave Council members time to remember Dr. Bishop. The formal memorial service is in Utah on April 10 and Dr. David Sundwall, former Chair of COGME, is representing the Council.

**Elizabeth M. Duke, Ph.D.**, HRSA Administrator, shared with Council members Agency activities and special initiatives during the current year. High priority is being given to implement HRSA□s hospital emergency preparedness program. $514 million in grant funding is expected to be made in August 2003, an amount quadruple that of FY 2002. This year Congress also provided $28 million for training and education for health practitioners to be prepared for bioterrorism. Dr. Duke discussed plans to expand the community health centers and the National Health Service Corps. HRSA is in the process of centralizing its grant offices from four to one and will be accepting future applications electronically. Review panels will also be reviewing applications electronically in the near future.

**Kerry Nesseler, R.N., M.S.,** Associate Administrator for the Bureau of Health Professions, discussed the Bureau□s strategic planning initiative. On March 18 and 19, 2003, fifty organizations were invited to discuss the Bureau□s strategic planning process (Dr. Carl Getto, COGME□s chairperson, represented COGME). The Bureau□s current mission is to increase health care access by assuring a health professions workforce that meets the needs of the public. Captain Nesseler shared the four functional mission statements of the Bureau: (1) to develop a health professional workforce through research analysis and planning; (2) to improve distribution and diversity of the health professions for rural, urban, and underserved areas; (3) to improve the quality of health professions practice and education; and, (4) to focus on key 21st century health professions issues. Captain Nesseler described various features of the performance measures developed in the Maternal and Child Health Bureau and stated that the Bureau of Health Professions will have to go beyond performance measures to more broadly conceptualized outcome measures to document its effectiveness.

**Jerald Katzoff, Acting Deputy Executive Secretary,** conveyed regards from Dr. Bastacky, COGME□s Acting Executive Secretary, who was unable to attend the COGME meeting. Mr. Katzoff reviewed the agenda and briefing book materials, and pointed to revised times for several of the presentations scheduled for the meeting.

**Impact of Malpractice Insurance on Physician Practice:**

**Emily V. Cornell, M.S.W., Program Director for Maternal and Child Health Policy Studies Division, National Governors Association.** Ms. Cornell provided the Council with an overview of the medical malpractice insurance crisis and its impact on physician practice. She stated that skyrocketing medical malpractice premiums are widely reported as a result of three factors: (1) the cyclical nature of the insurance market; (2) rising jury awards; and, (3) the decision of major carriers to leave the medical malpractice market. Ms. Cornell stated that other factors influencing the market and crisis are the events of September 11th, rising medical costs, medical progress and cost containment. She pointed out that the health care system is focused on restraining costs in health care expenditures and is unable to absorb financial stressors. She stated there is no one solution that will work in all

states because of differences in states insurance markets, state regulation of state insurance markets, physician coverage in rural vs. urban areas, and previous tort reform efforts and their status after legal challenges. The four types of solutions that are currently available are insurance market interventions, tort reform, alternative dispute resolution programs, and patient safety efforts. Ms. Cornell concluded her presentation by referring audience to the IOM report *Fostering Rapid Advances in Healthcare Learning from Systems Demonstrations*.

**Ross Rubin, Vice President for Legislative Affairs, American Medical Association.** Mr. Rubin, an attorney, stated that this is the third liability crisis the nation is facing. He stated that in June 2002 it was determined that there was a national medical liability crisis. He discussed major events that began in late 2000 which indicated that there were problems emerging. In some states liability insurance policies, as a condition of licensure, were not being issued. Physicians refused to work without a license and whole departments were closed. In the Fall 2002, the AMA conducted a survey in cooperation with 20 national medical specialty societies and 13 state medical societies. The survey was conducted online and covered issues of professional liability coverage and resulting changes in practice during the last two years. Survey results indicated that 58% of the physicians indicated that they had made some changes: 29% began referring complex cases with 91% of those indicating that liability was important to the decision; 19.4% stopped providing certain services with 81.6% of those indicating that liability was important to the decision; 5.6% stopped providing patient care with 74.1% of those indicating that liability was important to that decision; and , in all cases, reported actions were higher in high risk specialties and crisis states. Mr. Ruben concluded by stating that liability crisis is uneven across the U.S.; physicians are exhibiting adaptive behavior; impact is unclear, but it can be concluded that access to certain specialties and certain services are declining in parts of the country; and, graduate medical education is being impacted. Resident physicians are concerned about location and coverage requirements after completion of training and future location issues.

**Chip Slaven, Special Assistant to the Governor of West Virginia.** Mr. Slaven addressed the much publicized crisis regarding the malpractice insurance issue in West Virginia from the perspective of a local and very personal issue facing the State over a two year period. Over 60 percent of the doctors in West Virginia were insured by St. Paul and they were losing their insurance. The Governor called a special session in December 2001 and created BRIM (the state board of risk and insurance management). The BRIM II was created in order to provide malpractice insurance to over 1200 physicians who were having trouble securing insurance from another source. He stated that this provided an expensive but short-term solution that did help initially. Dr. Slaven discussed how the crisis escalated and the need to pass the Medical Liability Reform Bill (House Bill 2122). He stated that the Boards of Medicine and Osteopathy are responding to the crisis by implementing new standards of professional discipline of physicians and are developing new prerequisites for lawsuits and limits on third-party lawsuits. Mr. Slaven concluded by stating that it remains to be seen what effect these responses will have for West Virginia, a rural state.

Dr. Getto thanked the panel and stated that the topic of medical malpractice insurance is one that the Council will continue to address as it discusses GME issues.

**Impact of Residency Duty Hours Restrictions□Cost and Structural Adaptations:**

**Marvin R. Dunn, M.D., Director of Residency Review Committee Activities, Accreditation Council for Graduate Medical Education,** spoke on the new ACGME duty hour standards and their implementation**.** Dr. Dunn stated that the problem in dealing with graduate medical education is that it is a complex system and we are trying to apply the most linear system of measurement ever invented to this complex problem-- the clock in addressing duty hours-- and that is not the solution to the problem. He continued by pointing out that the issue deals with patient care, patient safety, resident safety, resident learning and cost. In September 2001 the ACGME charged a work group to develop a report and make recommendations on duty hours and their implementation. He described the goals of the effort and pointed out that one size may not fit all (programs). Dr. Dunn pointed out that the impact of the standards will be felt and there is a need to assess the organization and culture changes resulting from the new duty hour standards. He emphasized that the problem is the health care system. He stated that we have a broken health care system and the residents are simply being used to cover the system□s sins and grievances. Dr. Dunn discussed the issue of sleep physiology and sleep inertia of residents and its effect on providing health care. He concluded his presentation by presenting some examples of ongoing work by others, current ACGME efforts, and what will contribute to success.

**Mark Levy, Executive Director, Committee of Interns and Residents (CIR).** Mr. Levy stated that several years ago, the American Medical Student Association□s Legislative Affairs Director requested CIR□s assistance to look at residents' hours. A coalition was formed with CIR, AMA, and the American Medical Students Association (AMSA). Mr. Levy pointed out that CIR was formed as a union in 1957, and six years ago became affiliated with SEIU, the largest health care union in the country. CIR has long advocated for change in duty hours□indeed, in 1957, the first limit on resident work hours was achieved in New York City as a result of collective bargaining. Mr. Levy pointed to a study that suggested that residency training practices are largely determined by custom and tradition; has not been re-examined for a long time; and, has conformed to hospital pressures with little consideration of impact on residents. In order to have change in hospitals, we need to identify problems, look at what could be done better, and develop a practical plan that is greater than the resistance. About 50-60 common issues emerged that could be clustered into categories that were responsible for extending hours. The categories included: (1) whether the problem is a tradition or a resource issue; (2) which solutions could be reached quickly and which would take longer to do; (3) which solutions would have a low-cost and which would have a higher cost. The residents agreed that resident duty hours could be reduced from 2 to 5 hours per day without reducing schedules and many of those changes can be accomplished with little or no cost. Mr. Levy pointed out that programs/hospitals can make adjustments to accommodate resident hours limits. He provided points on didactic reforms by adjusting teaching; re-thinking resident schedules, examining patient flow impact on resident hours and the need to go outside-the-box by looking at staffing issues and determining what needs to be done by residents as opposed to other providers. Mr. Levy stated that reform efforts could run into resistance; overcoming resistance takes assurance of prompt and effective enforcement, recognition and rewards for ideas and best practices, and

allocation of institutional support and resources. He closed by stating that long hours and short staffing are bad medicine: bad for patients; bad for training.

**Danielle Carrier, Program Director for Operations Improvement, University Health System Consortium (UHC).** UHC is a cooperative of academic medical centers with 87 full members. All of the full members are affiliated with a medical school with a significant number of residency programs among them. Ms. Carrier described the types of products and services that the UHC□s provide: (1) management and information tools; (2) product procurement and preferred agreements; (3) improvement and effectiveness; and (4) strategic and enterprise management. The Consortium has begun a study of resident work hours particularly looking at what it will take in terms of resources of teaching hospitals to support organization improvement and the development of systems and processes to change behavior.

Public Comment: Ms. Sunny Yoder, of the Association of American Medical Colleges (AAMC) provided comments and stated that AAMC would be willing to work with COGME and other organizations to further the agenda on residents' duty hours.

The Council members adjourned for lunch at 12:24 p.m. and reconvened at 1:30 p.m.

**Assessment of Medicare□s IME Payment for GME**

**Craig Lisk, Staff Member, Medicare Payment Advisory Commission (MedPAC),** and **Robert M. Dickler, Senior Vice President, Association of American Medical Colleges.** Mr. Lisk discussed the most recent work of MedPAC on the IME (indirect medical education) adjustment for impatient payment (March 2003) with a brief historical review of the Commission□s meeting in January. He explained that the IME adjustment is a percentage add-on to Medicare inpatient PPS (perspective payment system) rates. When the PPS was established in 1983, an empirically derived estimate of the IME was doubled and put into place in the payment system. The doubling was achieved through reductions in the base payment rates for all hospitals. He pointed out that the preliminary analysis showed that teaching hospitals perform poorly under the perspective payment system. Congress was concerned about teaching hospitals□ performance under this system and wanted to ensure that hospitals would not be financially hurt with implementation of the new payment system. Time showed that teaching hospitals performed better financially under PPS than other hospitals. The adjustment has been lowered from about 11.6 to 6.5 in fiscal year 2002 and in 2003 it was set at 5.5 percent, the level expected to remain until changes are be made by Congress. He provided slides that demonstrated what the changes mean and how they affect the various teaching hospitals. He brought out that the Commission also looked at the missions that hospitals undertake (research, teaching, and stand-by capacity) , and recognizes that hospitals involved in these missions and major teaching hospitals, academic medical centers involved in these missions, varies substantially. Congress does not wish to lower the IME adjustment because of the extent of uncompensated care provided by hospitals and the desire of Congress to provide enhanced medical education to better prepare providers with the capacity to manage

the health care needs of Medicare beneficiaries. The Commission plans to discuss these issues over the coming year.

Mr. Dickler□s presentation addressed some of the technical issues demonstrated in Mr. Craig□s slide presentation and pointed out that hospitals with a greater number of residents get higher payments so there is curvilinear relationship. Mr. Dickler pointed out that since the word education is in IME, people assume it is for educational cost which, as pointed out, is really not the case. It is for the whole array of other costs which are grounded in some fairly sophisticated and important quantitative analyses and those need to be studied. Mr. Dickler then shifted to the policy level which asks why has Medicare for the past 20 years paid more than is justified in the care of Medicare patients. He provided examples of the issues to be studied further such as how narrowly or broadly should this money be used: just for Medicare support or for other societal missions such as□education, research, high technology services, introduction of new technology, stand-by services, and uncompensated care? He concluded by stating that MedPAC has undertaken some very important and challenging deliberations.

Following the presentation, there were a question and answer period. Dr. Getto concluded the session by stating that these two presenters would be invited back to provide updates.

The plenary session was adjourned at 2:33 p.m. to convene into two workgroups: GME Financing and Workforce.

**FRIDAY, APRIL 11**

The Council reconvened at 8:30 a.m. in the Versailles IV meeting room. Dr. Getto reviewed the agenda for the day and then introduced Mr. Mike Dyer, Legislative Liaison for AACOM (American Association of Osteopathic Medicine) who provided an update on proposed legislation which would impact on COGME□s future life and activities.

In Council discussions, a question was raised regarding the approval of the minutes. Dr. Getto stated that they were administratively approved last time because COGME terminated on September 30, 2002 and was not extended until late October 2002. In the future, as soon as the minutes are ready for review, they will go out electronically to COGME members for review and approval. They will then be posted on the COGME website within 90 days.

**Reports of the Work Group Chairs:**

**Dr. Royer, Chair of the GME Financing Work Group,** stated that the workgroup reviewed the contractor□s draft report, *State and Managed Care Support for Graduate Medical Education: Innovations and Implications for Federal Policy*. He referenced several passages and pointed out that the conclusions were really principles and not recommendations. Therefore, the workgroup recommends this study be published as a resource paper, not a

formal report with recommendations from either the work group or the full Council. Secondly, the workgroup will provide a foreword or a cover letter that will link the publication to COGME□s 13th report. It will emphasize some of the main points the workgroup thinks are critical.

ACTION: The Council voted to accept all of the recommendations made by the Financing Work Group.

**Dr. Schooley, Chair of the Workforce Work Group**, stated that the initial findings of the contract with the Center for Health Workforce Studies in New York were discussed during their work group meeting held the previous afternoon. The analysis of the workforce requirements for physicians through 2020 is based on two scenarios: one a demand-based scenario; and another, a need-based scenario. While the draft report contains suggested policy recommendations to begin to close the gap between projected demand and need, the work group did not discuss these policy recommendations. Dr. Schooley stated that the work group, however, did discuss and provided some guidance to the contractor on ways to further analytically refine the needs estimates produced. The work group also discussed ways for the contractor to elaborate and expand upon the ranges of requirements produced by quantifying the results of differing scenarios to be built into the model.

**Edward Salsberg, Director of the Center for Health Workforce Studies**, followed Dr. Schooley, and pointed out the difficulty in forecasting. While there are too many unknowns for anyone to be able to adequately or accurately forecast the future, he pointed out that there is a strong indication that over the next two decades, we will be facing a physician shortage. As the Council has been on record for many years in advocating the need for cutbacks in residency training because of a perceived projected surplus of physicians, it is important to signal a shift in perspective from one of surplus to shortage. He stated that if all else stays the same, the supply would be around 970,00 physicians in 2020. The Center forecasts the demand would be for about 1.1 million physicians and the need about 1.2 million. Under these scenarios and the assumptions made, the nation could be facing a shortage of 150,000 to 240,000 physicians. Mr. Salsberg pointed out the need to regularly reassess in light of changes in the environment, for example, the change in managed care and the change in physician practice patterns. He also pointed out the growing number of reports noting shortages in different specialties and the significant inflow of international medical school graduates.

At 10:21 a.m. the discussion was tabled and a ten minute break was taken.

Dr. Getto introduced the next speaker, **Ann Greiner, Deputy Director of the Board on Health Care Services of the Institute of Medicine.** Dr. Getto stated that the project grew out of COGME and the National Advisory Council on Nursing Education and Practice (NACNEP) meeting held about three years ago which focused on patient safety. Ms. Greiner presented an overview of the project□s report, *Health Professions Education: A Bridge to Quality*. She stated that the report concluded that □The American health care delivery system is in need of fundamental change. The current care system cannot do the job. Trying harder will not work. Changing systems of care will.□ She described the interdisciplinary summit and the report which focuses on integrating a core set of competencies into health professions education. The report□ recommendations include a mix of

approaches related to oversight process, the training environment, research, public reporting, and leadership. The recommendations targeting oversight organizations include integrating core competencies into accreditation, and credentialing processes across the professions. The goal is an outcome-based education system that better prepares clinicians to meet both the needs of the patients and the requirements of a changing health system. Discussion followed.

ACTION: Dr. Getto invited COGME members to e-mail Ann directly with ideas and thoughts. He also stated that the Council will either contact her directly or through Dr. Stan Bastacky, COGME's Acting Executive Secretary, regarding next steps.

ACTION: Dr. Pincus, Department of Veterans Affairs, agreed to send information on the performance measures for medical education that the Department developed in response to Government Performance and Results Act (GPRA) to COGME staff who will distribute it to all the members of COGME.

Dr. Getto then turned the discussion back to workforce issues. He opened the floor for comments about policy implications. Some time during the upcoming September meeting will be needed to discuss recommendations and the policy implications of the findings of the Center□s modeling activities performed on behalf of the Council.

There was no public comment.

Dr. Getto summarized the topics for the upcoming September meeting adopted during this session. They included: (1) follow-up on the workforce report; (2) having Ms Danielle Carrier and Ms. Sunny Yoder of the AAMC back to update and continue discussions on residency duty hour issues; (3) discussion of the restraint of trade suit brought against the National Residency Matching Program (NRMP); (4) a presentation on the University of Michigan Supreme Court case and its impact for medical school diversity initiatives; and (5) inviting back Mr. Dyer of the AACOM, to provide an update on legislation being considered that would impact on COGME□s future operations and activities.

Meeting was adjourned at 11:22 a.m.